NEW YORK STATEWIDE HEALTH REFORM DEMONSTRATION

FACT SHEET

Name of Section 1115 Demonstration:	The Partnership Plan
Date Proposal Submitted:	March 20, 1995
Date Proposal Approved:	July 15, 1997
Date Implemented:	Phase-in implementation began October 1, 1997
Amendment Submitted (Family Health Plus):	June 30, 2000
Amendment Approved (Family Health Plus):	June 29, 2001
BBA Extension Submitted:	March 29, 2002
BBA Extension Approved:	September 27, 2002
BBA Extension Expires:	March 31, 2006

SUMMARY

On July 15, 1997, New York's section 1115 Medicaid demonstration, entitled "The Partnership Plan," was approved. The demonstration is designed to move approximately 2.1 million Medicaid beneficiaries from a primarily fee-for-service delivery system to a mandatory managed care environment. The demonstration also expands health insurance coverage to the State's Safety Net (formerly Home Relief) recipients. As a result, 370,000 of the State's Safety Net recipients were converted to a Federal Title XIX eligibility group. Safety Net was a state-funded cash assistance program for low-income adults who were not otherwise eligible for Temporary Assistance for Needy Families (TANF) or Medicaid.

On June 29, 2001, the Family Health Plus (FHPlus) amendment to the demonstration was approved. This amendment expands health insurance coverage to additional low-income uninsured adults.

On September 27, 2002, a three-year extension to the demonstration was approved effective from April 1, 2003 to March 31, 2006, along with two amendments. One amendment phases out the Community Health Care Conversion Demonstration Project (CHCCDP) during the extension period. The other amendment, effective October 1, 2002, expands family planning services to individuals with net incomes at or below 200 percent of the Federal Poverty Level (FPL).

ELIGIBILITY

All Medicaid-eligible individuals, as well as the Safety Net and FHPlus populations, are included in the demonstration. When fully implemented, FHPlus will expand health insurance to childless adults with gross incomes at or below 100 percent of the FPL and adults with children with gross incomes at or below 150 percent of the FPL.

All managed care enrollees under the demonstration are given six months of guaranteed eligibility.

The following are not covered under the demonstration:

- individuals receiving care in long-term care facilities;
- individuals receiving hospice care;
- individuals who are served through a Home and Community-Based Services waiver program;
- individuals who spend down and become eligible for the Medically Needy program;
- infants of incarcerated women;
- individuals expected to be eligible less than six months (e.g., seasonal agricultural workers); and
- individuals with access to cost-effective private health insurance.

Enrollment for some groups is voluntary. In general, homeless individuals and most children in foster care are exempt from the demonstration with some allowance provided for county-by-county policy variations.

Currently, individuals dually eligible for Medicare and Medicaid are excluded from the demonstration. However, after the State develops capitation rates and other program features for this population, the State intends to require dually eligible individuals served by a Medicare risk plan to enroll in that plan for their Medicaid services and intends to allow other dual eligibles to voluntarily enroll in Medicaid contracting plans.

BENEFIT PACKAGE

Managed care enrollees in the Partnership Plan, excluding FHPlus, are entitled to the same comprehensive benefits package available under the fee-for-service program. Certain services, such as long-term care services, continue to be provided on a fee-for-service basis. Other services, such as transportation and dental care, may be provided on a fee-for-service basis or as part of the capitated managed care service package at county discretion. Family planning services can be obtained from any provider offering such services.

The State also offers certain services on a fee-for-service wraparound basis to individuals who exceed a basic benefit threshold within their managed care plans. For example, individuals who exhaust their basic benefits as defined in the capitation rates are able to receive mental health

inpatient and outpatient services, and medically necessary alcohol and substance abuse treatment services on a fee-for-service basis.

FHPlus benefits are less comprehensive than those offered by Medicaid. FHPlus does not cover long-term care services for the chronically ill, non-emergency transportation, medical supplies or non-prescription drugs, except for smoking cessation products. Limitations apply to home health services and inpatient psychiatric care. Dental services are available to the extent that the beneficiary's plan offers such services. FHPlus is a fully capitated model without carve-outs or fee-for-service wrap-around services.

ENROLLMENT/DISENROLLMENT PROCESS

The State has contracted with an independent enrollment broker who is responsible for outreach, education, and enrollment activities in New York City and Nassau and Suffolk Counties. Local Departments of Social Services (LDSS) outside New York City either use an enrollment broker or train in-house staff to perform these functions. For FHPlus, the broker will process the enrollments and disenrollments for FHPlus, but will not have a role in outreach and education. Instead, participating plans will be required to have marketing plans approved by the State. The State has also contracted with community-based organizations and health plans to serve as facilitated enrollers. These groups provide outreach to individuals and families in need of health insurance and assist them in completing the application. The application is then submitted to the LDSS for processing and an eligibility determination.

All Medicaid managed care enrollees are provided with 60 days to select a health plan. If no selection is made by the 60th day, the enrollee is auto-assigned to a health plan. Following health plan selection or auto-assignment, all enrollees are given a grace period of 90 days to change plans for any reason. After the grace period ends, beneficiaries are locked into their plans for the balance of one year unless they can provide good cause justification for transferring to another plan or disenrolling into the fee-for-service system.

FHPlus beneficiaries who choose a managed care plan are given a grace period of 90 days to change plans for any reason. After the grace period ends, beneficiaries are locked into their plans for the balance of one year. There is no auto-assignment process, as all FHPlus enrollees must choose a plan before being determined eligible.

Enrollment for some groups is voluntary. In general, homeless individuals and most children in foster care are exempt from the demonstration with some allowance provided for county-by-county policy variations.

The Partnership demonstration offers additional protections to clients with chronic illnesses, unusually severe conditions, or complex referral needs. For example, where such clients depend on specialists not in a contracted managed care network, they will have the opportunity to apply for an exemption from managed care enrollment and if enrolled, will have a right to an expedited disenrollment for cause. Similarly, managed care enrollees with conditions that require

specialized medical care over a long period of time may obtain a standing referral to an appropriate specialist or choose a specialist as their primary care provider.

DELIVERY SYSTEM

Under the demonstration, excluding FHPlus, the counties contract with Federally Qualified Health Plans, State Plan-defined Health Plans, and State-certified Prepaid Health Services Plans (PHSPs), which serve only Medicaid and other indigent clients. Capitated Special Needs Plans (SNPs) will be developed to serve individuals with HIV/AIDS, requiring intensive case-managed care regimens, and their families.

FHPlus enrollees must use providers within their FHPlus health plan that holds a contract with the State. The State has contracted with a commercial insurer to provide services to FHPlus recipients who are in the eleven counties that do not have FHPlus managed care plans.

QUALITY ASSURANCE

Under the demonstration, the State and contracting health plans are required to develop comprehensive quality assurance monitoring programs, including beneficiary satisfaction surveys and focused studies on significant health issues. The State will work with the AIDS Institute to develop relevant clinical standards and performance measures for the HIV/AIDS SNPs.

For FHPlus, quality health monitoring will consist of the same tools used for the Medicaid Managed Care Program, including Medicaid encounter data, Quality Assurance Reporting Requirements (QARR), member satisfaction surveys, and focused clinical studies by the State's External Quality Review Organization, Island Peer Review Organization. The intent is to merge the monitoring of the FHPlus program into the current activities conducted by the State's Office of Managed Care's Bureau of Quality Management and Outcomes Research.

COST-SHARING

There is no cost-sharing under the demonstration.

HOSPITAL RESTRUCTURING

As part of the July 15, 1997 approval of the Partnership Plan, a CHCCDP was set up. The purpose of CHCCDP is to facilitate the successful transition of qualified public and voluntary hospitals that have traditionally served the Medicaid population to a managed care environment. CHCCDP provides these hospitals with funding to restructure the workforce, as well as management information systems, and develop linkages to primary and preventive health care providers in community outpatient settings. CHCCDP is statewide, although a majority of the targeted safety net hospitals are located in New York City. Two hundred fifty million dollars in Federal funds are available to hospitals eligible for CHCCDP in each year of the five-year

demonstration. With respect to the extension, $250 million in Federal funds are available for year one and $100 million for year two.

CURRENT STATUS

Implementation of the demonstration, excluding FHPlus, on a county-by-county basis began on October 1, 1997. As of March 2003, twenty-one counties have implemented mandatory managed care for the TANF-related and Safety Net populations under the demonstration. These counties are: Albany, Broome, Cattaraugus, Chautauqua, Columbia, Erie, Greene, Livingston, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Oswego, Rensselaer, Rockland, Saratoga, Suffolk, Wayne, and Westchester. In addition, New York City (Phases I through V) has implemented mandatory enrollment for the TANF-related and Safety Net populations. Westchester is the only county which has implemented mandatory managed care for SSI individuals.

The State began enrollment into Family Health Plus on October 1, 2001.

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